Office of the Chief Medical Officer

TRICARE

Innovation Number: 8

Click here to view Poster

Part A. Contact Information

On File

Part B. Commander's Information

On File

Part C. Categorize Your Innovation

Readiness

Part D. Share An Innovative Program

Title of Innovation: "Leadership in Innovation with Proven Consistent Outcomes"

Date Submitted: 10/05/2005

Date Project Initiated: 10/05/2005

Background: Background: Through sheer reengineering and without major capital investment in technology and staffing, Naval Hospital Bremerton's (NHB) Disease Management program has demonstrated consistent positive clinical outcomes resulting in more innovations across the whole continuum of care since 2001, 4 years before the "Road Map to Successful Disease Management" guide and the Population Health Navigator became available. After organizing a multidisciplinary Diabetes Quality Improvement Team and using the Chronic Care Model (CCM) as our guide, we participated in the year-long Washington State Diabetes Collaborative program where we learned how to enhance our care integration capability by efficiently using our available resources and effectively improve our outcomes. NHB quickly achieved each element of CCM with diabetes starting by manually scrubbing our first registry, and reengineering the care and business processes. In early 2004, this same template was used to address our Breast Health Program. Both the Diabetes and Breast Health programs were referred to as the "Gold Standard" in care during the Surgeon General's FY-2005 Disease State and Condition Management Program Kickoff Sessions.

Methods: Methods: 1. Adaptable and Replicable Decision Support Tools Innovations: The diabetes management program (DMP) adapted the Diabetes Staged Management (DSM) model from the International Diabetes Center as the starting point for patient's diabetes care plan. This model allows our primary care providers to better manage more diabetics with more confidence, success and, enabled us to decrease the number of referrals to specialty care. The next innovation was the introduction of long and rapid-acting insulin protocols which were designed to promote teamwork between the diabetes care team and the patient in learning how to safely manipulate the dosage changes under a strict "Titrate-to-Target" protocol. These innovations enabled primary care support staff and the patient to work together as a team under a "patient-centered care" environment. This innovation can be easily adapted and replicated by any MTF. These protocols are all available via our NHB Intranet for easy access. 2. Sustainable and Institutionalized Integrated Approach to Disease Management: With the success in the use of DSM and the insulin protocols, NHB pioneered the integration of the diabetes management program from the primary care setting to the

inpatient management of hyperglycemia and diabetes under a closed-loop process which involved designing a DKA (Diabetes Ketoacidosis) protocol for the emergency department. Now the diabetes management process is imbedded anywhere in the continuum of care at NHB. 3. Cross–Functional Team implementation for disease detection: Women's Health Clinic (WHC) was developed with the cooperation of Health Promotion, Radiology, Family Medicine, Internal Medicine, Case Management, and Surgery. This clinic includes counseling, clinical breast exam, vaginal exam (pap if indicated) and a mammogram in one visit. Women 40 years and older who had not had a mammogram in the past two years and/or had not had a pap smear in the last three years were identified. These ladies are contacted by phone and offered an appointment to the WHC or with their Primary Care Manager (PCM). All NHB female beneficiaries over 40 are sent a birthday postcard to invite them to make an appointment to see their PCM for routine exams. If a patient is diagnosed with Breast Cancer, they get access to a Case Manager immediately to ensure patient is followed up both physically and psychologically.

Results: Bench-Marked Outcomes > NHB has been the leader in utilizing the elements of Chronic Care Model as the foundation of its disease management approach in diabetes and breast health programs as evidenced by how it has been consistently exceeding the HEDIS standard since 2001, a year after it officially deployed its diabetes management program (DMP). In 2004, the Breast Health program (BHP) was launched using the DMP template and as expected, its outcomes continue to rise steadily as more patients are empowered to manage their health. Currently, all improvement initiatives in both programs are tracked using the PDSA process. These improvement outcomes are presented to the NHB staff during our "Annual Quality week" competition where both programs were recognized and awarded the Patient Centered Care Process Improvement award. Patient-Centric Services > Patients enrolled in the BHP and DMP attend rigorous self-management workshops that promotes adherence and self-advocacy using the "Health Belief Model" principles and the popular "Motivational Interviewing" techniques during counseling session. The clinical practice guidelines for both programs are explained to the patients to promote transparency and ownership. Both programs also develop an individualized action plan designed to prevent exacerbations and complications. This partnership enables our primary care clinics to increase their capacity through integration of care. Preferred Partner > Non-MTF Prime beneficiaries frequently request access to both programs through word of mouth from our MTF beneficiaries who cite the expertise, the responsiveness and partnership philosophy exhibited by the care team as a reason why they stay with NHB.

Conclusions: Conclusion: Our Diabetes Management and Breast Cancer Detection programs consistently exceed the HEDIS expectations and have enhanced our patient satisfaction without an increase in our capital investment. This, along with our innovations, is very duplicable template that can be used to improve all other disease management processes anywhere in the world. Submitted by: Edward L. Lee RN CDE Jenni Osborne Women's Health Educator Naval Hospital Bremerton